

Below is an updated list of responses to questions received by CSoc.Helpdesk@la.gov through May 4, 2011, the last day for submission of RFA related questions. There may be additional clarification posted through May 13, 2011.

IMPORTANT NOTE REGARDING THE RFA PAGE LIMIT:

The guidance on page 3 of the RFA is correct. Letters of support, the application checklist, and the various forms (partnership list, acceptance forms, primary contact form) are not included in the 30 page limit. Please disregard the contradicting information provided in the May 4 webinar which was in error.

Questions Regarding Dissemination of Information

What does the 30 page limit include? After the webinar, we looked back through the RFA and noticed that on page 3 the directions state that “Application forms provided in the RFA (including the proposal checklist and acceptance forms) and letters of support do not count within the maximum page count.”

Answer

The guidance on page 3 of the RFA is correct. Letters of support, the application checklist, and the various forms (partnership list, acceptance forms, primary contact form) are not included in the 30 page limit. Please disregard the contradicting information provided in the May 4 webinar which was in error.

Will the approved applications for the first phase of the CSoc be posted on the website or be available for others to view?

Answer

A decision has not yet been made regarding the publication of the winning applications.

Where does one find the “DHH Banned from Business list”?

Answer

The Office of the Inspector General maintains a list of excluded individuals who are unable to participate as providers in Medicare or Medicaid. Check the link: <http://exclusions.oig.hhs.gov/> Individual providers who have been excluded from Louisiana Medicaid are notified via registered mail. Medicaid does not have a published list.

Can we obtain a copy of the power point presentation used in today’s (April 20) webinar?

Answer:

The PowerPoint has been posted on the CSoc website: www.dcfsls.gov/csoc

What time and where is the State Residential Provider Meeting? Who is allowed to attend this meeting?

Answer:

The statewide meeting will provide information necessary for residential providers to determine where their facility fits into the system and to identify requirements that must be met prior to implementation in January 2012. Each provider agency may send a maximum of two participants to the presentation, to be held:

April 20, 8:30 a.m. – 12:30 p.m.
9th Floor, Iberville Building
627 North 4th Street, Baton Rouge

Additionally, providers should be aware of the Request for Applications (RFA) process as it will affect future residential services. The RFA was released on March 15 with a May 13, 2011, application deadline. Additional information may be obtained from the website. DHH will host a technical assistance webinar on provider issues and related Medicaid information for the RFA on the same day as the statewide meeting from 1:00 p.m. to 3:00 p.m. DHH is making arrangements to broadcast the webinar from the meeting room so that interested parties can participate. If DHH is unable to accommodate the webcast, you may view the webcast on the CSoC website at a later time.

I am looking for some clarification as to whether the RFA for the Coordinated System of Care (CSoC), released on March 14, 2011, takes the place of the RFP that is anticipated for release for a Statewide Behavioral Health Management Organization? The RFI for this proposal was released September 15, 2010. If not, do you have an anticipated release date for the Statewide Behavioral Health Management Organization RFP?

Answer:

The RFA for initial implementing regions does not take the place of the RFP for the Statewide Management Organization (SMO). We anticipate the SMO RFP being released in mid May. Please check back to the CSoC website for updated information.

The CSoC Webinar "Provider Issues and Related Medicaid Requirements" is being held at the same time as the OBH technical assistance webinar for the RFA. I understand that the OBH Webcast will be viewable from the website, but it is not the same as being able to attend and submit questions in real time. While the PowerPoints from the CSoC Webinar series are being posted on the website, the audio/visual presentations are not being made available, and again the opportunity to post questions in real time is lost. Can you clarify so that providers have access to attending all CSoC related training?

Answer:

The OBH technical assistance webinar is the *Provider Issues and related Medicaid information* webinar. They are the same thing. We are not aware of any other webinar at that time. The webinars are not available for in person attendance- only via telephone and on line. We intend to post the recording of the webinar on the CSoC Website

Will the PowerPoint presentations from the March 15 meeting be published?

Answer:

The PowerPoint has been posted on the CSoC website: www.dcfsls.la.gov/csoc

Will the webinars be archived?

Answer:

Yes- the PowerPoint presentations will be posted on the CSoC website:

www.dcfsl.a.gov/csoc

Questions Regarding the Wraparound Agency

I was told that each parish is responsible for developing a WAA, is this correct?

Answer:

No, each region implementing the CSoC will utilize a single WAA for all parishes.

How will Case Management for the Wrap Around services be billed? Will Medicaid begin paying for services, such as home based case management since that seems to be an element of the WAA?

Answer:

As stated in the RFA on page 66, the following daily rate schedule identifies the per child per day estimated reimbursement. These rates are all inclusive for WAA services, including case management. These rates are provided for planning purposes and should not be interpreted as the final payment rates each agency should expect to receive from the SMO. They are provided to assist with financial planning.

Agency Size (in terms of wraparound teams)	Daily Rate per Child
One Team Wraparound Agency (capacity of 80 children)	\$44
Two Team Wraparound Agency (capacity of 160 children)	\$37
Three Team Wraparound Agency (capacity of 240 children)	\$34

Can a wrap around agency have on its board or have members or staff who are also employed by CSoC providing agency?

Answer:

It would be a conflict of interest for Wraparound Agency (WAA) staff to also be employed by a provider agency. As stated previously, providers may serve on the WAA governing board so long as the requirement for family participation is met, majority of board members are not providers and strict conflict of interest policies are adopted by the board.

Who will make the final selection WAA and FSO for Regions? Will it be the convening community group, the SMO or someone else?

Answer:

The Community's response to the RFA must include identifying a FSO and WAA. Representatives of these agencies must attest that their organizations meet the requirements specified in the RFA. If a community is selected by the CSoC Governance Board for phase one CSoC implementation, those named FSOs and WAA will be utilized, contingent upon verification of the attested information, completion of the

specified training and certification requirements, and enrollment with the SMO, including ongoing compliance with credentialing requirements.

Will there be WAA/FSO training related to forming healthy relationships with the thousands of local churches and faith communities in Louisiana which are important natural supports? The CSoC may appear to some as a government-funded (and therefore frightening) initiative.

Answer:

OBH will develop a training plan that takes into consideration the roles of the WAA and FSO within the community.

I read in the CSoC Application that the Award Announcement date is in June and that the launch date is January 2011, when would staffing need to begin? Is the Wraparound agency required to hire 36 new employees?

Answer:

The business model projections assume that the agencies would begin staffing up one month prior to beginning to see clients. Then their caseloads would gradually increase over the course of the year. The recommended staffing for a WAA is in the RFA. The required staffing ratio for Wraparound Facilitators to children/families is 1 FTE staff to 10.

If a region's FSO and WAA are separate, independent nonprofit organizations, must their independent formation and incorporations be simultaneous for a regions' selection? It's very likely that a region may be interested and meet criteria, but not have all the corporate structures in place by the stated deadlines.

Answer:

As stated in the RFA, the FSO and WAA must be incorporated and in operation by January 1 for start up implementation. They do not necessarily have to be incorporated at the date of submission of the response to the RFA, but the required information must be included in the response to demonstrate required criteria are met.

In the 3/15/11 RFA conference in Baton Rouge, Michelle Zabel stated that in one of the other states that has already implemented a CSoC (Maryland?), the providers within a region pooled resources to form a legal (corporate) entity to be the WAA for that region.

a. Would this be allowed in Louisiana provided all stakeholders within the WAA service area agree?

b. Would the founding providers be allowed to serve on the governing board of the WAA?

Answer:

a. yes

b. Providers may serve on the governing board so long as the requirement for family participation is met, majority of board members are not providers and strict conflict of interest policies are adopted by the board.

Can the wrap around agency be placed in one identified parish government if agreements are in place for provision of wraparound services for the residents of the other parishes?

Answer:

There is no prohibition against a local government agency serving as the wraparound agency as long as it does not have the authority to mandate service provision or refer to itself to provide services.

Can a provider that provides services in one region apply to be the Wraparound Agency in another region that they do not provide services in?

Answer:

This should be acceptable, with the understanding that there would be no ability for the agency to refer to itself for service provision. The agency will have to comply with CMS requirements for appropriate firewalls to prevent the ability to self refer, restrict beneficiary choice, or not provide full and complete information to a beneficiary. It is also expected that CMS will require that the WAA staff be housed and supervised completely separately from the provider staff.

If my agency covers more than one region in the state and provides direct services in another region, would it prevent the agency in the region without direct services from applying as a Wraparound Agency in the CSoC?

Answer:

No, with the understanding that there would be no ability for the agency to refer to itself for service provision. The agency will have to comply with CMS requirements for appropriate firewalls to prevent the ability to self refer, restrict beneficiary choice, or not provide full and complete information to a beneficiary. It is also expected that CMS will require that the WAA staff be housed and supervised completely separately from the provider staff.

If the Wraparound agency was put in a Juvenile Planning Board, would there be a problem with the planning board receiving Medicaid reimbursement?

Answer:

Due to the mandatory composition of the Child and Youth Planning Boards, a potential conflict of interest exists for it to serve as the WAA and therefore the proposal would not be considered.

The RFA states that “Because of the inherent conflicts of interest that might arise if WAA’s also provide the services they manage, WAA’s will not also act as service providers.” Can the WAA provide counseling and other services to children and their families who are not in the CSoC target population (youth under age 22 with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement)?

Answer:

No, it is anticipated that children and youth in the CSoC target population will transition out of CSoC and into regular Medicaid behavioral health services or the adult system. Therefore a conflict of interest exists.

Will the WSS and FSO be required to be licensed either through DCFS or DHH? And if not, why would there be no licensing governance?

Answer:

WAAs and FSOs are not facility based programs and do not require licensure. Certification requirements will be developed by DHH as described in the RFA that the WAAs and FSOs must comply with in order to contract with the SMO and deliver services to the CSoC children and youth.

Questions Regarding Regional Geographic Issues and Points of Contact

Can Agencies from Jefferson and Orleans parish coordinate together to form one WAA? If so, does it matter where they seat the coordinating agency? Will the coordinating agency be able to send WAA clients to participating agencies in the two parishes?

Answer:

If all stakeholders-- not just provider agencies-- agree and demonstrate commitment, Jefferson may participate with Region 1 (Orleans, Plaquemines, St. Bernard parishes). Jefferson and Orleans may not submit an application excluding Plaquemines and St. Bernard parishes. The WAA agency may have a physical office in any of the parishes, but staff must serve clients in the entire region over time.

Is Jefferson Parish excluded from participating in the INITIAL delivery of services under the new WAA or have they been assigned to any specific agency/agencies?

Answer:

Jefferson is not excluded; they are invited to submit an application to implement the CSoC either individually or as specified above, with Region 1.

How can I determine who is applying to be the lead agent for Region II?

Answer:

There is no lead agent for regional RFA responses. Each region is expected to organize its own key stakeholders to develop a collaborative response to the RFA. Those stakeholders who submitted an "Intent to Apply" email by 3/25 will be posted by region on the CSoC website with their contact information.

What is the process or who are the point of contacts for the FSO and WAA for Region 7? Is there a location on the website where this information can be obtained for all the regions throughout the state? Is there a calendar on the website with dates for when these meetings will be held in each region?

Answer:

FSO and WAA contacts participate in the larger community process for responding to the RFA. The contact information from all who responded by the March 25 deadline for the call for Notice of Intent to Apply will be posted on the CSoC website. Each region is responsible for organizing and publicizing its own meeting schedule.

Questions Regarding CSoC Implementation and Services

What is the upper age limit for children to receive services in the CSoC?

Answer

Children through age 21 may receive services in the CSoC.

An agency is interested in being a WAA and provides no services to children, but does provide Mental Health Case Management Services to adults. Does that lead to a conflict of interest for the WAA?

Answer

Some youth transitioning out of the CSoC may transition in to the adult service system, therefore a conflict of interest may exist.

Has the Waiver been approved yet? If not, what is the anticipated date of approval? How will the state move forward with implementation of the CSoC without the approval of the waiver? Will implementation, training, etc... be extended?

Answer

The waiver has not yet been approved. It may take six months or longer from the date of submission to gain CMS approval. CSoC implementation will not move forward until waiver approval is obtained from CMS and all the associated timelines will be adjusted accordingly.

I understand that the WAA will ramp up to 240 children. What is the occupancy rate to be expected at any given time once we are up and running at full speed? Are there any changes to the per diem rates at this time?

Answer

Each WAA is expected to serve 240 at any given time once full ramp is achieved. There are no changes to the per diem rates at this time.

How will developmental disabilities be covered in the CSoC for children who are dually diagnosed?

Answer

For children with behavioral health disorders and developmental disabilities, if the child has a severe emotional disturbance and otherwise meets criteria for the CSoC, they are eligible for services within the CSoC for their severe emotional disturbance. Expanded services provided under the State Plan by licensed psychologists, LCSWs and LPCs will be offered to all Medicaid children, including those with a developmental disability. Existing Waivers services for the developmentally disabled are not impacted by the changes to the BH delivery system.

What is the current MMIS system used in LA to pay behavioral health claims? Is the expectation that the SMO will pay all claims, or is the State open to some type of interface with its current claims system?

Answer

The current MMIS system processes all Medicaid claims. It is proposed that all claims will be paid by the Statewide Management Organization except for claims submitted by Local Educational Areas. The SMO will interface with the MMIS to provide encounter claims data necessary to draw down federal matching funds and to validate the SMO's invoice to Medicaid for claims it pays to providers.

What is the limit of cost for services per youth under Medicaid? Can you give an example of cost of limitation (where the SMO needs to discuss/ or suggestion for another plan). Of course, we understand the idea of wraparound services and usage of collaborative services of zero cost to minimum cost to maximize and cover the needs of the youth and family.

Answer

The Code of Federal Regulations specifies that States must provide early and periodic screening and diagnosis of eligible Medicaid recipients under age 21 to identify physical and mental defects and provide treatment to correct or ameliorate defects and chronic conditions found. Cost is not identified as a limiting factor.

The RFA document states in part that a “Licensed Practitioner of the Healing Arts...Is generally held to be a physician or licensed practitioner (see the OLP definition) acting in his or her scope – but not every practitioner (e.g., LPC or LAC) can do everything under their scope.”

a. I was not able to locate the definition of ‘OLP’ in the RFA document. Can you provide that definition?

b. The document states that “not every practitioner (e.g., LPC...) can do everything under their scope.” What exactly is it that LPC’s will not be able to do as defined by their scope of practice? Please be very specific.

c. Will LPCs be allowed to assess and diagnose?

d. Are LCSW’s included in the example (stated in parentheses)portion of the definition?

Answer

To meet time frames, the RFA language may have been developed prior to the final draft of the State Plan. a. The term OLP refers to Other Licensed Practitioners. This is a term from the Code of Federal Regulations which is defined as “Medical care provided by licensed practitioners other than physicians”. The proposed state plan defines the OLPs as individuals “...licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license.” The list includes Medical Psychologist, Psychologist, LCSW, LPC, LMFT, LAC and APRN.

The intent of the State Plan language is to ensure all LMHP staff operate within the scope of their practice. The proposed state plan states “LMFTs and LACs are not permitted to diagnose under their scope of practice under state law. LPCs are limited by scope of practice under state law to diagnosing conditions or disorders requiring mental

health counseling and may not use appraisal instruments, devices or procedures for the purpose of treatment planning, diagnosis, classification or description of mental and emotional disorders and disabilities or of disorders of personality or behavior, which are outside the scope of personal problems, social concerns, educational progress and occupations and careers.”

c. See b. above

That questions about potential Medicaid fraud are asked in public town hall meetings is evidence that many doubt the ability of any governance structure or state department to adequately control for fraud. What measures are in place to ensure that wide spread fraud will not occur and that, if it should occur, fraud perpetrated in one region or part of the system will not endanger the entire CSoC?

Answer

The Department of Health and Hospitals shares your concerns regarding potential fraudulent activity. The Statewide Management Organization (SMO) will be required to have a quality management strategy that will be reviewed and approved by the Office of Behavioral Health. The SMO will use a variety of methods to monitor provider performance. These activities will be conducted on a regular basis and monitored by the Office of Behavioral Health and an Interdepartmental Management Team. DHH also works closely with the State Attorney General's Medicaid Fraud Control Unit to ensure prosecution of fraudulent providers.

If a provider's CANS assessment of a child varies significantly from a CANS administered by the WAA, what will the mechanism be to resolve the difference in assessment?

Answer

The CANS is administered by an independent evaluator. The Wrap Around Agencies and service providers will not administer the CANS separately. Resolution of problems occurs within the Child and Family Team meetings.

How many new employees will be required within the Department of Health and Hospitals to support, operate or maintain the CSoC once it is fully implemented?

Answer

It is anticipated the SMO will assume some job duties currently performed by state employees. The number of Department of Health and Hospital (DHH) employees needed within Medicaid and Office of Behavioral Health to operate the CSoC has not yet been determined. DHH is responsible for funding, developing State Plan, rules and policies, provider training, quality management, as well as various other administrative, legal, and communication responsibilities, including contract oversight for the SMO.

When will provider reimbursement rates be made public?

Answer

Medicaid is facilitating a workgroup including experts and stakeholders to set the residential and outpatient rates. A completion date is not known at this time. This is a complex process and will be completed as soon as possible. Refer back to the DCFS website for updates, www.dcfs.la.gov/csoc

Will the public corporation selected to function as the CSoC's State Management Organization be required to declare all previous and current relationships with Mercer and other consultants to the CSoC's development? Will all relationships and potential conflicts of interest related to the SMO and any consultant to the development process of the CSoC be made public? Will the SMO be required to declare previous relationships it has with providers in other states?

Answer

A copy of the Request for Proposal has been posted on the Department of Health and Hospitals website, www.dhh.la.gov (select Behavioral Health/Publications). On page 186, there is a section on conflict of interest. It is the intent of the Office of Behavioral Health that there are no conflicts of interest involving the Statewide Management Organization and any involved parties.

A chronic problem with Special Education and mental health facilities state-wide is that the guardians are often unable to come to the facility for meetings designed to address assessment, reassessment, case planning, etc. due to job demands, lack of transportation etc. A large number complain that attending such meetings places their employment at risk as employers are unwilling to allow the time off for such meetings.

- a. ***Will the case managers from the WAAs and other team members (such as special education staff, teachers, probation officers, child protection/foster care staff, psychiatrist, private clinicians, etc.) be required to meet with families in their homes and after business hours and on weekends if necessary to conduct the assessments and team meetings in an effort to better accommodate such logistics within the family?***
 - a.1. ***If the guardian and or child is unable to attend the scheduled team meeting, can the remainder of the team proceed with the assessment, reassessment, and/or case plan?***
 - a.1.a ***If not, will funding for existing services to the family continue until a team meeting with guardian and child in attendance can occur?***
 - a.2 ***If one or more of the non-family members of the family team is unable to attend the team meeting, but the youth and guardian are in attendance, can the other members of the team proceed with the meeting?***
 - a.2.1 ***If not, will funding for existing services to the family continue until such time that all team members are present?***
 - b. ***Even when services are routinely offered in the home and after hours and on weekends as is the case with MHR agencies state wide, "No Shows" by consumers and other team members for team meetings is a chronic problem. If the guardian, youth, and/or other team members are unable/unwilling to meet with the family team for the reauthorization family team meeting prior the end of the treatment authorization period, will funding for services to the identified youth continue if:***
 - b.1 ***Only the guardian is not present?***
 - b.2 ***Only the identified youth is not present?***
 - b.3 ***Only one of the non-family team members is not present?***
 - b.4 ***More than one of the non-family team members is not present?***

Answer

- a. Some of the core values and principles of the CSoC are: Family-driven and youth-guided, home and community-based, strengths-based and individualized, culturally and

linguistically competent. In keeping with these principles, stakeholders will be invited to participate and every effort should be made by the WAA to schedule meetings at a time that will accommodate the schedule of all necessary participants. The details of how the teams will operate have not been determined but meetings should be held at a location and time best for the child and family.

a.1 The client and family should be present for all assessment, reassessments, and case plan meetings.

a.1.a . Medically necessary services are available to eligible clients.
Every effort will be made to prevent a lapse in services.

a.2 That decision should be made by the client and family.

b. The State Management Organization will provide details during provider training. The details regarding what will be funded and what will not be funded has not been determined at this time.

Procedural details such as this have not been finalized. In general, Medicaid can only reimburse when a covered service is provided to an eligible recipient by a Medicaid eligible provider.

Hypothetical: Shaundrecia Smith is a 14-year-old female who upon assessment was diagnosed with Major Depression-Recurrent-Severe with Psychotic features, Post-traumatic Stress Disorder, ADHD Combined Type, Polysubstance Abuse, and Conduct Disorder. She has a history of very frequent out-of-school suspensions for bullying/fighting, and truancy. She is currently serving a two-year period of court imposed probation for conviction on multiple battery charges and for being ungovernable. This clinical scenario is typical of a large number of high risk youth that will be served by the CSoC. Currently, there is no single Evidence Based Program or Practice (EBP) that will address several of these issues at once, much less all of them. Additionally, very few if any individual providers will be credentialed to provide the broad array of EBPs that will be necessary to address all of Shaundrecia's diagnoses/symptom clusters.

Questions:

- a. Which empirically sound assessment protocol will be used to determine which EBP(s) is most appropriate for any one of the diagnoses or symptom clusters, much less multiple diagnoses/symptom clusters?***
- b. If all of Shaundrecia's diagnoses/symptom clusters are to be addressed at once, will the family be required to see several therapists (Each offering a different EBP) over several appointments weekly? Or,***
- c. If her diagnoses/symptom clusters are to be prioritized and addressed one two or more at a time, what empirically sound assessment protocol will be used to determine how that prioritization will occur, and who will make the final decision?***

Answer

It is proposed that the Statewide Management Organization (SMO) will conduct an initial screening to determine if an independent assessment will be needed. An assessment will begin the process of determining if a client qualifies for services and to begin to identify what the strengths and needs of the client. A person centered plan will be developed to identify the goals, objectives, and services. If an evidence based service is needed, a referral will be made to the appropriate service. The specific assessment process and instrument (s) has not been determined at this time.

How will the new CSoC ensure psychiatric coverage state-wide when such coverage being provided by MHR agencies state-wide will be disassembled and cease to exist upon implementation of the new CSoC? Will the new CSoC pay psychiatrist an average of \$250.00/hour as is currently the average rate for psychiatrist contracted by MHR agencies? Many if not most psychiatrists have stated that they will not work for less because they can completely subsidize their practices with out-of-pocket private pay clientele at a minimum of \$250.00 – \$350.00/hour. If not, where will CSoC consumers go to obtain psychotropic medication management services?

Answer

First, it is not the intent of Medicaid to “disassemble” MHR agencies. There will be changes to the names and description of the services but essentially, recipients will continue to receive, individual/group skills training, counseling, medication management, group counseling, and assessment. There will be expanded clinical services, addiction services, and residential services. Medicaid will be offering training in the next few weeks to continue orienting providers to the program changes. Regarding the rates for psychiatrist, Medicaid is facilitating a workgroup including experts and stakeholders to set the residential and outpatient rates. A completion date is not known at this time. This is a complex process and will be completed as soon as possible. Refer back to the DCFS website for updates, www.dss.louisiana.gov. The final rates will be posted on the LA Medicaid website, www.lamedicaid.com.

Who will conduct the initial and ongoing assessments for those youth served by the WAAs vs. those who are not?

Answer

The evaluations to assess eligibility for the CSoC and Non-CSoC youth are performed by licensed mental health professionals practicing under their scope of practice as permitted under State law.

How will these assessments be used to develop a case/treatment plan for those youth served by the WAAs vs. those who are not?

Answer

The assessment will be reviewed by the Wraparound Facilitators with the child and family team to identify the strengths, needs, goals, objectives, and services to develop a person centered plan of care. For non-CSoC youth, the assessment is reviewed and services are authorized by the SMO.

Who will develop the case/treatment plan for those youth served by the WAAs vs. those who are not?

Answer

The child and family team will develop the plan of care for youth eligible for coordinated system of care (CSoC) services. For youth not receiving CSoC services, the Statewide Management Organization will ensure the plan of care is developed by a licensed mental health professional.

It was stated clearly in several of the CSoC Town Hall Meetings that the Licensed Mental Professionals who conduct the initial and subsequent reassessments for the Wrap Around Agencies (WAAs) will not be in the employ of the WAA. We therefore wish to pose the following questions:

- a. Will the licensed mental health professional who conducts the assessments be the same licensed professional who develops the treatment plan, and will the licensed professional who develops the treatment plan be the same licensed professional who provides clinical services? If not:***
 - a.1. If the licensed mental health professional who provides direct clinical services to the consumer conducts his/her own intake assessment (as is required by the various codes of professional conduct), and that assessment yields clinical findings significantly different from that obtained by the WAA, how will the discrepancy be resolved?***
 - a.1.a To what appeal process will the dissenting licensed professional and consumer have access?***
 - a.1.b. Who shall have ultimate decision making authority?***
 - a.1.c Will the consumer have access to Medicaid funded behavioral health services while the appeal is being conducted? If yes,***
 - a.1.c.i. What will be the process for conducting an assessment and treatment plan designed to drive services under such circumstances, and who will provide the services?***
 - a.1.d. If the consumer does not agree with the ultimate decision, will they still be able to choose some other provider outside of the WAA and have their services funded under Medicaid?***
- b. How will the answer to these question differ for those youth served through the WAAs vs. those who are not.***

Answer

CMS requires that an independently Licensed Mental Health Professional (LMHP) conduct the assessment. The LMHP may or may not be employed by the WAA.

a.1. , a.1.a, a.1.b The Statewide Management Organization will have an appeal process for providers and clients. The operational details have not been developed at this time.

a.1.c , , The Statewide Management Organization and LA Medicaid will ensure clients have access to the federally required appeals process and that all medically necessary Medicaid services are available during the appeal process.

a.1.d Once a final appeal decision is rendered, it is binding on both DHH and the consumer. If the consumer disagrees with the decision, they may pay out of pocket for the provider of their choice.

b. The basic process is the same for CSoC and non-CSoC services.

Have the new waiver and revised Medicaid State Plan been submitted to CMS for their review and approval? If not, when do you predict that will occur? If yes, when do you predict CMS will make a determination on their acceptance or rejection of the plan? Have there been any discussions with CMS about these items, and what has been their response?

Answer

The waivers and state plan amendments were submitted to CMS on March 10, 2011. It is difficult to predict when CMS will accept or reject the state's requests. Medicaid

personnel will partner with other stakeholders to respond to CMS inquiries as quickly as possible to do our part to help ensure a decision is made in the shortest period of time. As of May 3, 2011, meetings are being scheduled with CMS to review questions and comments.

Judging from Mr. Greenstein's community meetings across the state, there seem to be several health care CSoCs evolving all at once including the one for behavioral health. Is there a reason for this? Will all of these CSoC's eventually be merged under one CSoC and one State-wide management company? If so, when do you predict this will happen? Will this involve another major revision/revamping of the behavioral health system of care?

Answer

For a number of reasons, the state has proposed two separate managed care systems: the Coordinated Care Networks (CCN) for primary health care and Coordinated System of Care (CSoC) for behavioral health care. The CSoC will contract with a Statewide Management Organization to manage both Medicaid and non-Medicaid funded services. The CCNs will utilize separate contracts. Managed Care in Louisiana will be new for providers and clients and will probably evolve and change in years to come. At this point, it is impossible to when or what those changes might entail. The CSoC Statewide Management Organization is expected to be contracted by September 2011. For more information about the Coordinated System of Care visit the Office of Behavioral Health website, <http://new.dhh.louisiana.gov/index.cfm/subhome/10/n/6>

It's been said that MHR providers are well positioned to transition efficiently and effectively to service delivery under the CSoC. Do you agree? If so, why? If not, why not?

Answer

Yes. Because MHR providers are accredited, provide home and community-based services and have experience operating in a managed care environment, which includes meeting certain standards, qualifications and certifications, they should be situated positively for the transition.

I understand that the current provider base under Medicaid will be expanded to include individual practitioners in addition to private agencies. Will individual mental health professionals be able to work as 1099 employees for a private agency? If so, will they be able to link their tax identification and NPI numbers to a private agency's tax ID and NPI number so that reimbursement for the individual provider is linked to the agency's tax identification number as is currently allowed under private payment systems?

Answer

Unfortunately, that is an operational detail that has not been developed at this time. The Statewide Management Organization will be available to answer staffing and contracting questions during implementation, which is expected to be in the fall of 2011.

Currently, MHR providers bill for services rendered weekly and are paid one week later. Do you anticipate any delays in payment beyond this schedule when we

transition to the CSoC? What is being done to ensure a smooth payment transition?

Answer

We do not anticipate any delays in the reimbursement process however it is impossible at time to say if it will be within 7 days. Medicaid regulations regarding timely claims payment are specified in CFR 447.45 and must be met by the SMO. Once the SMO has been selected and a contract has been signed (sometime in August) the SMO will work with DHH, DCFS, OJJ, DOE and Medicaid to establish a process and train providers.

Concerning the hundreds of consumers currently being served by MHR agencies: Will they be able to continue receiving services from existing MHR service providers under the new CSoC? If so, what is the plan for ensuring smooth transition from the current MHR service delivery system to the CSoC service delivery system in a manner that ensures no interruption in services to consumers? What is the plan for ensuring no interruption of reimbursement for provider agencies?

Answer

Clients will be able to continue to receive services from their choice of providers if the provider meets all requirements to be in the provider pool and is enrolled with the SMO. A number of details related to this question are still being developed. Ongoing dialogue with providers, status updates, technical assistance and training during the implementation phase are being planned and will help to ensure a successful transition. The SMO has been selected and a contract has been signed (sometime in August) the SMO will work with OBH, DCFS, OJJ, DOE and Medicaid to establish a transition plan and train on the process.

Has the rate of reimbursement structure for services under the new CSoC been developed? If so, can we get a copy? If not, when will they be available?

Answer

Medicaid is facilitating a workgroup including experts and stakeholders to set the residential and outpatient rates. A completion date is not known at this time. This is a complex process and will be completed as soon as possible. Refer back to the DCFS website for updates, www.dss.louisiana.gov. The final rates will be posted on the LA Medicaid website, www.lamedicaid.com.

It is my understanding that implementation of the CSoC may not occur across the entire state at the same time. Will current service delivery continue in those regions of the state that do not implement initially? If not, how will it be different? Will we operate two systems of care, old and new simultaneously, for the near future? If not, how will this be prevented?

Answer

Correct. There will be a phased in approach based on regions. Service delivery will continue with some changes. It is anticipated providers will enroll with the Statewide Management Organization. The SMO will be responsible for screening and prior authorization. Additional provider types and services will be available. We will not

operate two systems of care. Although CSoC will be phased in, the five state plan amendments are expected to be implemented statewide. There is ongoing planning and preparation being conducted by a number of groups for the transition including the modification of existing rules and/or creation of new rules to support the changes.

It is my understanding that all providers will have to provide services under the new FFS, managed care, wraparound system. But I don't see anything about national accreditation (i.e., JACO, CARF etc) that we in MHR are required to maintain. Will we be required to maintain accreditation under the CSoC and if so, will Non-MHR providers including the public MHCs be required to do the same.

Answer

Medicaid is currently developing provider qualifications and rules. It is anticipated that accreditation will be a requirement for most provider agencies, including mental health clinics.

Can you outline the services we will be able to expand to/contract for/ bill for under our current structure?

Answer

The services are outlined in state plan amendments and home and community based waivers submitted to the Centers for Medicare and Medicaid. Select the link for more information. Detailed service descriptions, rules and regulations are currently being drafted for publication in Rule and manual at a later date.

<http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1568>

Will MHR agencies be required to obtain a new certification and/or contract with the SMO and/or Wraparound Agencies, or will we be grandfathered in because of our current certification and accreditation?

Answer

The details regarding certification and/or contracting with the Statewide Management Organization have not been finalized, but it is anticipated that certification requirements will closely resemble current MHR requirements. At this time, there are no plans to allow providers to be "grandfathered. The certification/contracting process is an operational detail that will be available at a later date.

It is my understanding that the Wraparound component will be only one aspect of the new 1915 Waiver and revised Medicaid State Plan. Can you provide a brief explanation of how the various components of the 1915 Waiver and revised State Medicaid Plan will work to shape the new CSoC service delivery system? Where does the new SMO and WAAs fit into this and how will the new waiver shape/dictate their powers across Wraparound and non-wraparound services?

Answer

Medicaid submitted state plan amendments that, if approved, will expand medically necessary individual, group, addiction, rehabilitation, and residential services for recipients. The 1915 (b) waiver allows the state to contract with a Statewide Management Organization (SMO) to manage all behavioral health services, both Medicaid and non-Medicaid. The 1915 (b) waiver, if approved, will also include the

same CSoC services for youth at risk for out of home placement who are not eligible for the 1915 (c) waiver as well as treatment planning for all youth who are at risk of out of home placement. The SMO will contract with the Wraparound Agencies to develop treatment plans and to coordinate services. All state plan service providers will be contracted by the SMO and all claims will be paid by the SMO.

Currently, mental health services funded under Medicaid, including MHR, are considered "carve out-optional services." Will this change under the new 1915 Waiver and/or revised Medicaid State Plan? What do you anticipate will be the impact of the looming budget deficit on funding of MHR services in FY 2011-12? What do you predict will be the impact of the looming budget deficit on funding for the CSoC in FY 2011-12? Do you predict that Health Care Reform and Parity will have any effect on protecting funding for behavioral health services in Louisiana? If so, what?

Answer

Required and optional services are defined by CMS (see CFR 440.210 and 440.225. We are unaware of any proposed changes in these Federal regulations. The proposed changes in LA's Medicaid State Plan and the Waivers would expand mental health services. The budget deficit faced by state government is one of the main motivating factors in the redesign of the behavioral health delivery system which aims to better leverage state dollars. DHH is committed to ensuring medically necessary services are available. The impact of Health Care Reform and Mental Health Parity legislation is still being studied. Federal guidance is anticipated.

Do I understand that if a Region is not selected for Phase I, that any agency/program in that Region will have to be on "hold" until Phase II?

Answer:

If a region is not selected for Phase I implementation of the CSoC, the WAA and FSO organizations will not be implemented at that time and will wait for Phase II. The Medicaid state plan services will be implemented at the same time statewide, regardless to whether the region is a Phase I implementing region or not.

Will the list of experiential therapies covered by the CSoC include all those which are included in Maryland's RTC Waiver: Art, Dance/Movement, Equine-Assisted, Horticultural, Music, Psychodrama/Drama Behavioral Services? Reference: "RTC Waiver Service: Expressive and Experiential Behavioral Services":
<http://medschool.umaryland.edu/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=2147485582>

Answer:

No

Many providers of Medicaid-funded programs offer several services in single facilities. A hospital may have an ER, a cancer unit, a cardiac care unit, etc. Will large, campus-based providers be permitted to provide different levels of out-of-home care and non-residential services on a single campus?

Answer:

Louisiana will provide guidance on how a multiple program provider's site can be licensed for multiple programs. The State has developed a policy document related to how multiple facility ownership will be addressed for facilities wanting to become a part of the Coordinated System of Care (CSoC). The policy document is in final review and is anticipated to be released shortly. The presentation to residential providers, dated April 20, 2011, will also address this issue

The document, "TN11-10-CSoC-EPSDT.pdf", states:

"TGHs may not be Institutions for Mental Disease. Each organization owning Therapeutic Group Homes must ensure that the definitions of institutions are observed and that in no instance does the operation of multiple TGH facilities constitute operation of an Institution of Mental Disease."Please provide a clear statement about the similarities and differences between a PRTF and an IMD, and between a TGH and an IMD.

Answer:

The State has developed a policy document related to how multiple facility ownership will be addressed for facilities wanting to become a part of the Coordinated System of Care (CSoC). The policy document is in final review and is anticipated to be released shortly. The presentation to residential providers, dated April 20, 2011, will also address this issue. This will be included in the PowerPoint presentation on April 20, and addressed in the policy document to be released shortly.

(State Medicaid Manual 4930. Institutions for Mental Diseases [IMDs]) – An IMD is defined in the original Medicaid legislation P.L. 100-360 as an institution for mental diseases; a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can become a PRTF if they meet the CMS regulatory requirements of a PRTF. These facilities are not IMDs because IMDs are defined to be institutions with more than 16 beds. Therefore, not all PRTFs are IMDs.

Similarly, not all IMDs are PRTFs. PRTFs are non-hospital accredited and physician-directed facilities meeting Medicaid PRTF requirements to provide inpatient psychiatric care. While services may be rendered to individuals of any age in a PRTF, Medicaid will only pay for services delivered to individuals under age 21 meeting medical necessity criteria. As noted above, an IMD can be a hospital, nursing facility or other large facility of more than 16 beds, which encompasses more facilities than just PRTFs.

CMS prohibits IMDs from providing rehabilitation services to Medicaid enrollees. Therefore, IMDs may not provide TGH services, which are authorized under the Medicaid Rehabilitation Option, to Louisiana SMO enrollees. Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can become a TGH if they meet the Louisiana Medicaid rehabilitation requirements of a TGH. These facilities are not IMDs because IMDs are defined to be institutions with more than 16 beds.

Will participation in any Medicaid-funded CSOC program place any limits on a provider regarding the provision of services to any other non-Medicaid client?

Answer:

Providers will be permitted to provide services to both Medicaid and non-Medicaid members (e.g., Department of Children & Family Services (DCFS) and Office of Juvenile Justice (OJJ)) of the Statewide Management Organization (SMO), as well as individuals not enrolled in the SMO (e.g., private paying patients).

How will the CSoC address the concept of separation for providers with multiple Medicaid-funded programs on a single site?

Answer:

The State has developed a policy document related to how multiple facility ownership will be addressed for facilities wanting to become a part of the Coordinated System of Care (CSoC). The policy document is in final review and is anticipated to be released shortly. The presentation to residential providers, dated April 20, 2011, will also address this issue.

If a provider were planning to establish Treatment Group Homes (TGH) in multiple regions, would looking at parish population data be the best way to identify initial locations - assuming the need is evenly distributed among the population and the CSoC's desire is to locate the small number of children who may require out-of-home care as close to their families as possible? Or will the SMO publish a list identifying target areas for the establishment of TGH's?

Answer:

At this time, the State estimates that approximately 250 beds in Psychiatric Residential Treatment Facilities (PRTFs) and 322 Therapeutic Group Home (TGH) beds will be needed. The State does not know exactly where those beds will be needed at this time.

Will the CSoC disallow funding for health care, dental care, and pharmacy services/medication which are not included in approved per-diem rates for children in PRTFs?

Answer:

(State Medicaid Manual 4930) – PRTFs are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the recipient's situation are assessed, and that treatment for those needs is reflected in the Plan of Care, per 42 CFR 441.155. In addition, the PRTF must ensure that the resident receives all treatment needed for those identified needs. For services provided by and in the facility that can be reasonably anticipated on the Active Treatment Plan, the PRTF must ensure that the resident receives all services identified on the Active Treatment Plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the recipient's situation.

The prospective per diem rate is considered payment in full for Medicaid-eligible portions of the payment rate, per 42 CFR 447.15, and may not be balance billed to the family or legal guardian.¹ This means the activities must be provided by the facility and no

¹

additional payments will be made by Medicaid, families or legal guardians (child welfare) for the provision of activities, which should reasonably be anticipated and on the resident's treatment plan. The family or legal guardian (e.g., child welfare) is responsible for paying for any services that cannot be anticipated (e.g., infections or broken bones) or are not provided by and in the facility (e.g., inpatient care).

The Medicaid per diem rates will be established with the understanding that emergencies will occur. Medicaid will pay for services that are provided in the facility, by the facility and on the Active Treatment Plan. Services not anticipated and not included on the Active Treatment Plan (e.g., emergency room or physician office visits for infections or broken bones), and those that are not provided in and by the facility, will be the responsibility of the family or the legal guardian.

¹ Service activities in the base prospective per diem rate that are not provided by and in the facility, and that reasonably should have been anticipated and placed on the active treatment plan and provided by and in the facility, may not be charged to the family or legal guardian, because the payment is considered to be payment in full for those Medicaid eligible portions of the payment rate per 42 CFR 447.15.

Given the capricious nature of Medicaid-funding (which providers have already experienced as a progressive series of reductions in reimbursement rates), has the CSoC prepared reimbursement protections for providers to ensure a stable reimbursements?

Answer:

The State of Louisiana intends to develop fair reimbursement rates incentivizing in-home and community-based evidence-based practices over residential and inpatient services. However, the State is unable to control the economy and budgetary pressures of the State. It is certainly the intent of the State to look at quality and utilization of medically necessary services.

Has any independent, nationally recognized entity such as the National Institute for Mental Health researched these questions and if so, what are their findings?

Answer:

The White Paper released in 2010 regarding Juvenile Justice Reform in Louisiana provides a robust collection of national research references.

http://publichealth.lsuhsu.edu/lamc/pdf%20files/EBP%20Whitepaper%20FINAL%20FEB%202010%20_3_.pdf

The CSOC model, specifically the Wrap Around Agency, is well researched. Information can be accessed on the internet at The University Of Maryland Institute of Innovations and at <http://www.nwi.pdx.edu/>

The new CSoC requires that providers engage in Evidence Based Practices and Programs. The cost of staff training during the first year alone for most of the EBPs ranges from \$20,000.00 – \$40,000.00. Is there any plan to assist providers financially with the “up-front” cost of such training? If so, how will this occur?

Answer:

No “up front” financial assistance will be provided; however, some training will be made available.

Have there been any discussions about shared training costs for agencies (either Provider agencies or State agencies) in providing training in the Homebuilders Model of intensive home based services? Currently, DCFS pays for the specialized training as well as ongoing QA (from the Institute for Family Development) for teams providing the service to DCFS clients. With CSoC, agencies may start to receive referrals from other sources beginning in January.

Answer:

For the initial CSoC implementing communities, the current workforce development/training strategy is anticipating the provision of some assistance.

Concerning public mental health centers vs. private providers:

a. Will public MHCs have to operate under the same waiver and revised Medicaid State Plan as do private providers?

Answer:

Yes. The state does not operate mental health centers. The state provides clinical treatment through licensed mental health clinics. Licensed practitioners within licensed mental health clinics will be required to meet the same LMHP standards for practice.

b. Will public mental health centers be required to support themselves financially on the same FFS payment system as private providers?

Answer:

Yes. Public mental health centers will use the same fee for service (FFS) payment system.

c. Will they have access to other federal and/or state sources of funding that are not available to private providers?

Answer:

State operated centers delivering mental health services (OBH or local governing entities behavioral health centers) are funded to provide treatment services to non-Medicaid eligible persons with serious mental illness.

d. Will public mental health clinics have to sustain themselves solely on revenues generated through the FFS reimbursement system like private providers must do?

Answer:

See response to C above.

e. Will public mental health centers have to credential and contract with the SMO and cooperate with the Wrap Around agencies like the private providers?

Answer:

Yes

f. Will public mental health centers be held to the same QA/QI and UM outcome measures as private providers?

Answer:

Yes

g. Will they be required to obtain national accreditation if such is required for private providers?

Answer:

Yes, eventually national accreditation will be required for all service providers.

How many OBH employees will actually have supervisory and management authority over the SMO?

Answer:

OBH is the designated purchaser of services for the Bureau of Health Services Financing. As such, there are certain monitoring responsibilities that CMS requires the State to perform.

On the DHH Office of Behavioral Health web page there is a membership list for the LA Mental Health Planning Council. Is this group going to have a role in the future of the CSoC?

Answer

The LA Mental Health Planning Council will continue to perform the role as advisor to the state mental health authority for the implementation of the federal public law 102-321, which mandates that states have a strategic plan for building community-based mental health services for the seriously mentally ill.

Are children ages 0 to 5 included in the description of high need or at risk?

Answer:

Yes

Can the CANS be used to screen children ages 0 to 5?

Answer:

Yes

Are families without Medicaid eligible for the CSoC?

Answer:

All children who meet the eligibility criteria for the CSoC as indicated by administration of the Child and Adolescent Needs Assessment tool (CANS) may receive CSoC services, whether the child is Medicaid eligible or not.

What is the criteria in becoming a Provider in the CSoC?

Answer:

Providers interested in participating in the CSoC program will enroll with the Statewide Management Organization (SMO). The SMO is a managed care company that will enroll providers, clients, and pay claims. The state is expected to release a request for proposal for the SMO in Mid May 2011. The SMO is expected to be operating in September 2011. At that time, the SMO will begin the process of educating providers regarding the enrollment process. Please check the Department of Health and Hospital website over the next 3 months for up to date information. www.dhh.la.gov.

How will the Provider be reimbursed for services rendered?

Answer:

The final reimbursement methodology has not been finalized. Please refer to the authority documents posted on the link below. Each document has a rate method submitted to the Center for Medicare/Medicaid. LA Medicaid continues to wait for final approval. It is expected that most services will be reimbursed as a fee for service. Residential services may be reimbursed as a per diem. There may be other services reimbursed as a weekly rate. <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1568>

What is the Fee Schedule for services?

Answer:

The fee schedule has not been finalized at this time. Effort is underway to set a rate for each service.

Given that foster families do not currently receive the full cost of caring for foster children will the CSoC enable Louisiana's DCFS to fully reimburse foster families the entire cost of providing care to foster children?

Answer:

For regular foster care board payments, the state has no current plans for increasing the rates provided to regular foster families. The CSoC will not govern regular foster care board payments. Routine annual budgetary consideration will continue with regard to the need for regular board rate increases.

It is my understanding that Behavioral Health contracts with providers funded through DOE, DSS, and OJJ that are paid with SGF dollars will be terminated and the funds pooled under the new CSoC. When do you project that those contracts will be terminated?

Answer:

Many behavioral health services currently funded with state general funds will transition to become Medicaid reimbursable services as a result of an amendment to the Medicaid state plan and waiver applications. Most of these will go into effect when the new state plan is implemented, currently scheduled for January 1, 2012. If the contract held by a current provider includes these services, the provider will need to work to become a certified Medicaid provider and contract with the SMO. As the details of the implementation schedule become more defined, DCFS and OJJ will communicate directly with their existing provider networks to assist providers to make the transition to become Medicaid providers to deliver needed services.

How many of each residential bed type (PRTF, TGH) will be needed by the CSoC?

Answer:

We are initially planning for 250 youth to be served within PRTFs and a maximum of 322 TGH placements. The exact number of PRTF's and TGHs has not been determined; that will be done upon consideration of needs and location of youth requiring this level of care. More information on this will be available on April 20 at the State Residential Provider meeting

How will DCFS's current contracts for Independent Living services (Transitional Living programs and Life Skills Training services) fit into the CSoC's provider structure?

Answer:

DCFS will continue to provide the current contracted Independent/Transitional Living/Life Skills training for our youth in foster care through our contract providers in each region. These regularly provided services are not going to be part of the CSoC. However, the CSoC will potentially open up opportunities for enhanced services to youth with intense behavioral health needs.

In the Glossary of Key Terms and Acronyms as well as in footnote 17 on page 55 of the RFA the acronym "OLP" is used.

"17 Licensed Practitioner of the Healing Arts: Under Medicaid regulations, medical necessity for rehabilitative services must be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law, and they must be furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a individual to his/her best age-appropriate functional level. This is generally held to be a physician or licensed practitioner (see OLP definition) practicing in his or her scope – but not every practitioner (e.g., LPC or LAC) can do everything under their scope."

There is no definition for OLP in the Glossary of Key Terms and Acronyms and no further explanation of what is meant by "but not every practitioner (e.g., LPC or LAC) can do everything under their scope." Please explain what limitations will be place on practitioners and give a rationale for limiting the scope of practice under certain practice licenses within the CsoC. This directly relates to how a Region may assess readiness and gaps in services. For instance, in Region 9 there are very few practicing psychiatrists and/or psychologists. If a physician or psychologist is necessary to determine medical necessity, then this would certainly be a gap in the region. However, if other LMPs are able to assess medical necessity as is determined by their scope of practice such as LCSWs, LPCs, or LMFTs, then this would not be a gap in the region.

Answer:

The Federal definition is found at 42 CFR 440.60 Medical or other remedial care provided by licensed practitioners. "Medical care or any other type remedial care provided by licensed practitioners" means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of

practice as defined under State law.

In Louisiana, 42 CFR 440.60 includes the following:

A licensed mental health practitioner (LMHP) is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently:

- § Medical Psychologists
- § Licensed Psychologists
- § Licensed Clinical Social Workers (LCSWs)
- § Licensed Professional Counselors (LPCs)
- § Licensed Marriage and Family Therapists (LMFTs)
- § Licensed Addiction Counselors (LACs)
- § Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. In addition, they may not be debarred, suspended, or otherwise excluded from participating in procurement activities under the State and Federal laws, regulations, and policies including the Federal Acquisition Regulation, Executive Order No.12549, and Executive Order No. 12549. In addition, providers who are an affiliate, as defined in the Federal Acquisition Regulation, of a person excluded, debarred, suspended or otherwise excluded under State and Federal laws, regulations, and policies may not participate.

All services must be authorized. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery. In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by DHH, in addition to their scope of practice license. LMFTs and LACs are not permitted to diagnose under their scope of practice under state law. LPCs are limited by scope of practice under state law to diagnosing conditions or disorders requiring mental health counseling and may not use appraisal instruments, devices or procedures for the purpose of treatment planning, diagnosis, classification or description of mental and emotional disorders and disabilities, or of disorders of personality or behavior, which are outside the scope of personal problems, social concerns, educational progress and occupations and careers. Per the State's practice act and consistent with State Medicaid Regulation, Medical and Licensed Psychologists may supervise up to two Clinical Psychologists.

Inpatient hospital visits are limited to those ordered by the individual's physician. Visits to nursing facility are allowed for psychologists if a PASRR (Preadmission Screening and Resident Review) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Visit and may not be billed separately. Visits to ICF-MR facilities are non-covered. All LMHP services provided while a person is a resident of an IMD such as a free standing psychiatric hospital or psychiatric residential treatment

facility are content of the institutional service and not otherwise reimbursable by Medicaid. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHH. A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

Please note however, that the independent practitioner must be enrolled with the Statewide Management Organization (SMO). Medicaid beneficiaries may choose to access services through any network provider who provides the appropriate level of care.

The SMO contractor is required to contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the state of Louisiana credentialing criteria, who agree to the standard contract provisions, and who wish to participate. The SMO contractor is required to provide at least as much access to services as exist within Medicaid's fee for service program. Within the Plan's provider network, recipients have a choice of the providers which offer the appropriate level of care. Rehabilitation providers must be employed by a rehabilitation agency, school, or clinic licensed and/or certified and authorized under State law to provide these services. Rehabilitation Agencies must be certified by the Department of Health and Hospitals. Mental health clinics must meet the licensure standards for psychiatric facilities providing clinic services as determined by the Bureau of Health Services Financing, Health Standards Section. The SMO will be encouraged to collaboratively develop networks with service accessibility and required to sub-contract with providers necessary to fill any service gaps existing in the SMO.

Enrollees will have free choice of providers within the SMO and may change providers as often as desired. If an individual joins the SMO and is already established with a provider who is not a member of the network, the Louisiana SMO will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network. In addition, if an enrollee needs a specialized service that is not available through the network, the SMO will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, enrollees will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area. .

In addition, consistent with requirements in 42 CFR 438 and because of historic quality of care behavioral issues in the State, the Statewide Management Organization (SMO) must have credentialing and recredentialing policies consistent with federal and state regulations. The SMO must evaluate every prospective subcontractor's ability to perform the activities to be delegated prior to contracting with any provider or subcontractor. The SMO is not obligated to contract with any provider unable to meet contractual standards. In addition, the SMO is not obligated to continue to contract with a provider who does not provide high quality services or who demonstrates utilization of services that are an outlier compared to peer providers with similarly acute populations and/or compared to the expectations of the SMO and State. The SMO's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The SMO must have a written contract that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation, terminating

contracts, or imposing other sanctions if the subcontractor's performance is inadequate.

The SMO must monitor all subcontractors' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The SMO must identify deficiencies or areas for improvement, and the subcontractor must take corrective action.

When will applications for providers be available outside of the WAA applications?

Answer

If you are asking how to enroll as provider to offer the Coordinated System of Care services as well as other Medicaid and non-Medicaid funded services, the details have not been finalized. At this time, it is expected the process will include a certification process developed and implemented through a partnership between the state of Louisiana and the Statewide Management Organization (SMO). Current and potential providers will be offered training and support prior to implementation. The SMO is expected to begin offering training in late summer or early fall 2011. Refer back to the CSOC website or the Department of Health and Hospitals, www.dhh.la.gov for more details

Once the CSOC is in place next year, will agencies that provide Medicaid funded services still be able to accept referrals directly from schools, clients, etc... or will all referrals have to go thru the wrap around agency?

Answer:

Although clients are encouraged to freely choose among available providers/agencies, the accepting agency the referral must be enrolled/approved by the SMO, meet pre-established quality and access standards, and all services provided must be prior authorized by the SMO. Once the CSOC and other state plan services are in place, the process for accepting referrals, performing assessments and required treatment planning will differ, depending on the client's eligibility and age. All state plan services for those 21 years old or younger must be authorized/reauthorized by the SMO. For those eligible for the CSOC services (including wraparound planning), all services must be approved by the Wraparound Agency or the SMO. For those 22 years of age or older, an independent assessment and plan of care must be established prior to being approved by the SMO to receive designated services. For children outside of the CSOC, they must have a service plan developed, which will be approved by the SMO for all rehabilitation services (unlicensed staff) and authorization by the SMO for services provided by licensed staff.

The criteria in the 1915c waiver states "meets criteria for psychiatric hospitalization placement" which is very different than at risk of out of home placement criteria in the RFA, for example, homeless, foster care or detention. Will the youth the meeting the target population automatically meet criteria or will they also have to meet criteria for psychiatric hospitalization?

Answer:

The target population for CSOC is broader than just children eligible for Medicaid financing. The CSOC target population is children and youth with significant behavioral

health challenges or co-occurring disorders that are in or at imminent risk of out of home placement defined as:

- “ Addiction facilities,
- “ Alternative schools,
- “ Detention,
- “ Developmental disabilities facilities,
- “ Foster care,
- “ Homeless as identified by DOE,
- “ Psychiatric hospitals,
- “ Residential treatment facilities, and
- “ Secure care facilities

The Child and Adolescent Needs Assessment will be the assessment tool utilized to determine if a child or youth meets the criteria for the CSoC target population and includes identifying children at risk for additional out of home placements, not just those who meet criteria for psychiatric hospitalization.

The 1915(c) waiver is a contract with the federal government regarding the Medicaid financing of certain services for Medicaid eligible children in Louisiana. Some limited services will be financed through Medicaid if a child within the CSoC meets certain institutional criteria (e.g., psychiatric hospitalization and nursing facility criteria).

I am writing to ascertain any information that you may be able to provide concerning the services in the Coordinated System of Care. I would like to know if you can provide me a web link or any specific information on the definition of crisis intervention services and/or case management services as may be covered in the CSoC.

Answer

The service definitions are still being developed and are not available for distribution at this time. Please refer back to the CSOC website in the next 60 days.

In a question last week, the answer referenced not being able to waitlist people in one region when capacity exists in another. Does this mean “slots” may be reallocated from one region to another if not being used?

Answer:

While we do not expect any region to serve less than 240 children/youth when fully implementing the CSoC, federal Medicaid requires that the slots are allocated on a statewide basis in the 1915(c) Medicaid waiver. So if there are 480 "slots" allocated in the first year of the program for two participating regions, if there are 250 children in one region and 230 children in another region, CMS will require the State to accommodate the 480 children regardless of their region.

A psychiatric treatment model is, by definition, focused on the amelioration of a narrow portion of a patient’s physiological and behavioral health needs. The CSoC’s documents describe a philosophical approach incorporating holism, or the concern for a patient’s whole being. What are the particular techniques the CSoC seeks to implement to meet the requirements of this philosophical stance and allow providers to deliver care in an holistic manner?

Answer:

The CSoC is seeking to support four primary types of interventions through this RFA. These interventions are described throughout the RFA, and the RFA must be viewed as a whole when defining them (including web links to additional documentation). Specific pages in the RFA that offer key definitional material for each are provided below.

1. A System of Care: See pp 14-15 of the RFA for key definitional material.
2. Wraparound Facilitation: See pp 16-18 of the RFA for key definitional material.
3. Youth Support and Training: See pp 70-71 of the RFA for key definitional material.
4. Parent Support and Training: See pp 71-72 of the RFA for key definitional material.

What are the benefits a region accrues by applying to be a first implementer?

Answer:

First round implementing regions will benefit by serving children and youth and improving outcomes earlier and potentially in greater number cumulatively over time.

What percentage of the 3:1 Medicaid-funding the CSoC will bring into Louisiana will be spent on new organizational structures versus the provision of direct services to children?

Answer:

There will be administrative costs associated with CSoC implementation but those have not been finalized. A goal of the CSoC is to streamline administrative costs through coordination and reduced duplication across the four agencies enhancing service effectiveness.

How many jobs is the CSoC expected to create in Louisiana given that each of nine regions is expected to have at least one WAA and one FSO? With the formation and staffing of the 20 new nonprofits required to implement the CSoC, what is the final ratio of all CSoC staff to participating children expected to be after full implementation has been achieved across Louisiana?

Answer

FSOs and WAAs may be new corporations or existing corporations meeting the mandated criteria. They may hire new staff or transition existing staff into new roles. Full implementation is expected to serve a minimum of 2,400 children per year, but expansion is expected as need and capacity is assessed over time. A ratio of CSoC staff to children/youth served is impossible to calculate at this time.

If a region is not chosen as one of the initial site or if they are not ready to apply by May 13th, when will they be able to apply? Will there be another RFA or can they apply as soon as they are ready?

Answer

The details of phase 2 implementation have not yet been determined, however the current budget projects round 2 regions implementing in FY 12/13

We were told that each region will only be able to serve 248 children. Is this accurate? What happens with subsequent children that are referred? Obviously they will receive any services they can outside of CSoC, but will they be put on a waiting list with the WAA and picked up when another child is discharged from CSoC? Or are they just rejected? Is it possible for a region to serve more than 248 children in a year? Will that number increase if it is shown to be lower than the number of kids who qualify and need CSoC services?

Answer:

It is not anticipated that more than 240 children/youth per region would be identified as needing CSoC services in year 1. If more children in a single region than the 240 children that can be staffed by the FSO and WAA are found eligible for the CSoC in year 1, then the SMO will be expected to provide Treatment Planning and waiver services for any Medicaid child eligible for CSoC. The State Governance Board will monitor access to services and direct expansion or changes to CSoC implementation, including any amendments to the waivers as needed. However, in no circumstance is the SMO/State allowed to waitlist children in one region if there is capacity in another region or statewide due to federal prohibitions on rationing medical care for eligible children by region within a state.

If an out of home placement for a CSoC eligible child is deemed necessary and authorized by the SMO, can family support services still be available to the family members and reimbursed?

Answer:

Yes

Please clarify whether the FSO for a region will be utilizing other family support services of non-profits to complement FSO services (not duplicate). There are many service providers in the community that provide supportive services to families, but would not be the FSO. Will these agencies be a referral resource for WAA plan of care or will the services of the non-FSO agencies be excluded.

Answer:

Only FSOs identified through the RFA process and contracted with the SMO may deliver and be paid for "Youth/Family Support and Training" as described in the RFA. Other services and natural supports (including family support groups and other supports provided by other non-profit agencies) will be determined as needed by the family and youth through the Child and Family Team planning process.

If I currently operate an OJJ Tracker/Mentor service how does this RFA affect the service I provide for the state? Should I consider becoming a part of this process?

Answer:

All community stakeholders are encouraged to become involved in the RFA process currently underway in local communities. It is important the community and potential WAA and FSO be aware of existing service providers. It is also important that service providers have knowledge of the process through which youth will navigate the coordinated system of care and were providers have the potential to interact with CSoC.

All eligible providers are also encouraged to begin educating themselves about the process of becoming eligible for Medicaid services. You can find additional information on the DHH website at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1568> Of particular importance to providers is to monitor the statewide management organization (SMO) development. Once that statewide entity is chosen through the RFP process, learn how to become connected to the SMO for referrals.

For existing OJJ contracts, if your service becomes a Medicaid billable service, you must become eligible to bill Medicaid and register with the SMO. For non Medicaid eligible services, the contracting process with OJJ will remain the same. It is possible once the new system is in place, the mentor and tracker services will be contracted separately. In that situation, mentor services may be Medicaid eligible and contract through the SMO and tracker services will remain contracted with through OJJ. As these decisions are made, the information will be communicated directly to existing providers.

Please clarify whether transportation services is reimbursable for the CSoC services. Transportation is a major barrier for many families seeking services. There may be some home-based services offered, but may not be possible for all services specified in the plan of care.

Answer:

Children and Youth in the Medicaid will have access to standard Medicaid transportation services for services under the State Plan including services by licensed and unlicensed practitioners.

Questions regarding Governance

How will the CSoC itself be protected from federal fiscal policy that will require continued cuts to the Medicaid system?

Answer

A reduction in federal spending for Medicaid may have an impact on Medicaid funding in Louisiana. If this were to happen, such a reduction may or may not have an impact on CSoC. LA Medicaid will continue to work with each participating office in state government, stakeholders, and government officials to ensure funds are available for the CSoC.

Is the Department of Education acquiring real “buy in” from a significant number of the parish school boards?

Answer:

School districts have not been able to recover costs for behavioral health services in the past. At times like this when fiscal planning and responsibility are equal to the

challenges of student accountability, the "buy in" to be reimbursed for services rendered and the opportunity to collaborate with community providers is being very well received.

Will the CSoC ensure that funds received by local and parish school boards for the provision of school-based behavioral health services will be used only for those services and not disbursed among other school-based programs or initiatives? If yes, then how will this oversight occur?

Answer:

Policy guidelines to address this issue are currently being discussed. As we move closer to 1/1/2012 start-up date, school district personnel will receive training as needed to appropriately implement all aspects of the CSoC.

On the Governance Board application under the qualifications section it says that the advocate cannot have staff overseeing activities as part of the system of care. This basically means that if Goodwill has someone who is interested in applying, we cannot be involved in any other aspects of CSOC. Do I understand this correctly?

Answer:

The intent is to minimize conflicts of interest, therefore if an advocate is a member of the Governance Board, then the advocate may not participate in any decision regarding the agency employing the advocate doing business or contracting in CSoC implementation.

Will any legislation be introduced during the 2011 Regular Session relative to the implementation of the CSoC? If so, what will that legislation attempt to do?

Answer

We do not anticipate filing legislation to support the CSoC implementation at this time.

How will the FY 2011/12 Executive Budget, to be presented on March 11, reflect the implementation of the CSoC? Where will it be referenced in the budget?

Answer:

The CSoC is reflected in DHH's Medicaid budget expenditures and included in the Interagency Transfer amounts within the DCFS, OJJ and DHH OBH budgets.

Currently, the MacArthur and Anne E. Casey Foundations are engaged in juvenile justice and detention center reform efforts respectively in LA. Both propose to accomplish the same outcomes and serve the same at risk youth as does the CSoC by creating coordinated service delivery systems. Have these initiatives been incorporated into the CSoC planning and proposed service delivery system?

- a. If not, are we at risk of having several systems of care each duplicating the efforts of the CSoC, competing to serve the same at risk youth, and creating a new method of duplicating services and fragmentation of services?***

Answer:

The Leadership Team is looking at all programs and initiatives to build partnerships and collaborate with CSoC implementation.

Questions Regarding Family Support Organizations

Can you provide a definition for 'systems-experienced' youth and families?

Answer:

System-experienced youth are "those who have been involved with the services such as mental health, child welfare, and/or juvenile justice systems." System-experienced family members are family members of "system-experienced" youth.

Source:

Strachan, R., Gowen, L. K., & Walker, J. S. (2009).

The 2009 Portland National Youth Summit Report. Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Portland State University.

How can the FSO legally inquire about the applicant's children and their status/involvement within these multiple public systems?

Answer:

Opened end questions allow applicants to discuss their life experiences.

Would there be a conflict of interest if the FSO had contracts with any of the providers providing services to the children/families in the CSoC? If so, why?

Answer:

No, there would be no conflict

An agency wishing to be considered as a FSO has non-profit and for-profit parts of the same agency. Can an agency be considered as a FSO if it has a for-profit part of the agency that is currently providing services? The FSO would be the non-profit part of the agency.

Answer:

If the FSO is affiliated with a an agency providing services in the CSoC, there would be a conflict of interest.

At the Webinar on 3/30/11 it was mentioned that the rate of reimbursement per 15-minute unit of service provided by the FSOs is anticipated to be \$10.00. What is the anticipated lower and upper range of units/client/week that will be approved for reimbursement?

Answer:

As stated in the RFA, for planning purposes, the following service delivery assumptions went into the development of the rates. When at full capacity (and fully staffed per the requirements in Section 5.H):

Each FSO will serve a caseload of 240 children and their families:

- 15% of the children and youth will access Youth Support and Training - Individual for an average of 2.0 hours per week
- 100% of the families of enrolled youth will access Parent Support and Training - Individual for an average of 1.5 hours per week, and

- 100% of the families of enrolled youth will access Parent Support and Training - Group for an average of 2.0 hours per week.

Will a Family Service Organization be permitted to maintain offices in the facilities of a provider?

Answer

This may create a perceived conflict of interest, therefore It is preferred that the FSO not have its primary corporate location housed within a service provider